BURLINGTON AREA SCHOOL DISTRICT
HEALTH SERVICES DEPARTMENT
Rosemary P. Dolatowski, RN MS
Jackie Betzen, RN BSN
100 North Kane Street
Burlington, WI 53105
(262)763-0210 (262)763-0215 FAX
www.basd.k12.wi.us

DENTAL HEALTH

Last Name ______________________ First Name ____________________ MI ______

School ______________________ D.O.B.____________________ Grade ______

Parent/Guardian____

Address____

TO THE PARENT/GUARDIAN:
Our school has a health program that is designed to improve, protect, and promote the health of each child. As a part of this health program we strongly urge you to take your child to a dentist of your choice at least twice a year for a dental examination and whatever treatment may be necessary. When the examination and treatment are completed, this form should be returned to the school.

TO THE DENTIST:
Check one of the following statements before signing this form:

1. Teeth were found in satisfactory condition. ☐
2. All necessary dental work has been completed. ☐
3. Some dental work is necessary and in the process of being completed. ☐

Signature of Dentist ______________________________ Date______________

Please Print Dentist's Name ______________________________________

State of Wisconsin
Department of Regulation and Licensing

KINDERGARTEN EYE HEALTH EXAMINATION REPORT

Student's Name ______________________ Birth Date ________ Sex ________

Parent or Guardian ______________________ Phone ________

Address ______________________ County ________

School/Kindergarten ______________________ City ________

Date entering Kindergarten ______________________

The State of Wisconsin encourages parents of Kindergartners to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician by December 31 of the child's first year in school. An examination or evaluation should include, at a minimum, the elements listed below. (By checking the box, the examining doctor is indicating that the element checked was performed.)

- ☐ Brief history (general health and eye health) of the child, including family history
- ☐ General external observation of the child's eyes and surrounding structures
- ☐ Ophthalmoscopic examination through an undilated pupil
- ☐ Gross measurement of peripheral vision
- ☐ Evaluation of eye coordination and function (alignment and motility)
- ☐ Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended: ☐ Yes ☐ No

Date of examination:

____

Doctor/Physician Signature:

____

Print or stamp:
Doctor/Physician Name
Address
Phone

IMPORTANT NOTICE TO PARENTS

This examination is not required by law. Disclosure of the information noted above is necessary to comply with the statutory purpose as outlined in s. 118.135, Wis. Stats.

Disclosure of this information is voluntary and there is no penalty for non-compliance.

You are encouraged to provide a copy of this form to the school and keep a copy for your record.

Consent of parent or guardian: I agree to release the above information on my child to appropriate school authorities and consent to my child obtaining an eye examination.

Signature ______________________

Date ______________________

#2540 (2/02)
s. 118.135, Stats.